

VACCINE ADMINISTRATION AND SCREENING RECORD

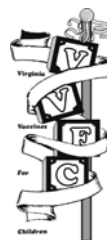
Patient Name: _____

Practice Address: _____

Date of Birth: _____

Medical Chart Number: _____

Physician: _____



VACCINE Administered (Please circle when choices are given)	Admin. Date (M/D/Y)	Eligibility Screening* (use key)	Vaccine Manufacturer	Vaccine Lot Number	Site (Optional)	Expiration (M/D/Y) (Optional)	Vaccine Admin's Initials	VIS Pub. Date	Parent or Guardian (Optional)
DT / DTaP 1									
DT / DTaP 2									
DT / DTaP 3									
DT / DTaP 4									
DT / DTaP 5									
Hib 1									
Hib 2									
Hib 3									
Hib 4									
Hep A 1									
Hep A 2									
Hep B 1									
Hep B 2									
Hep B 3									
HPV 1									
HPV 2									
HPV 3									
Influenza 1									
Influenza 2									
IPV 1									
IPV 2									
IPV 3									
IPV 4									
Meningococcal									
MMR 1									
MMR 2									
Pneumococcal 1									
Pneumococcal 2									
Pneumococcal 3									
Pneumococcal 4									
Rotavirus 1									
Rotavirus 2									
Rotavirus 3									
Varicella 1									
Varicella 2									
Tdap									
Td									

Combination vaccines should be documented under each antigen.

SIGNATURE OF VACCINE ADMINISTRATOR(S)

***ELIGIBILITY SCREENING**

Patients must be screened each visit prior to vaccination.

Receive free vaccine because they are <19 y/o and,

M = Child has Medicaid or Medicaid HMO
U = Child is Uninsured
A = Child is American Indian or Alaskan Native
I = Ins. does not cover imm. (FQHC/RHC/CHC only)

Receive free vaccine because:

S = Private Insurance, school required vaccine
AD = Adult Immunization (IPV, MMR, Td Only)

Receive privately purchased vaccine because:

P = Private Insurance, not school required vaccine

Name
Title

Name
Title

Name
Title

Name
Title

If more lines are necessary, please use the back.